PROVIDER BULLETIN

NOVEMBER 2009 Fourth Edition, Issue 1 Network Providers

A Publication of the Local Mental Health Plan of the County of Los Angeles Department of Mental Health

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INSTITUTIONS FOR MENTAL DISEASE – APPROPRIATE SERVICE LOCATION CODE

Effective immediately, network providers and billing agents are required to identify services rendered in Institutions for Mental Disease by entering service location code (facility type) 32 on electronic claims submitted to the Department of Mental Health (DMH) for reimbursement.

BUSINESS RULES REGARDING THE USE OF LATE CODES

Attached for review and compliance are the "County of Los Angeles Department of Mental Health Business Rules for Late Submission of Short-Doyle/Medi-Cal (SD/MC) Claims for Good Cause Reasons (i.e. Late Code Usage)." This document provides notification that re-emphasizes prior County Department of Mental Health (DMH) communication to network providers about their responsibilities regarding the proper use of good cause late codes. Network providers are reminded that any Medi-Cal claim submitted with the use of a late code is subject to audit. No or inadequate documentation for the use of a late code will result in the service(s) being disallowed and reimbursement will be recovered by DMH and/or the State. Refer to the attached business rules for late submission document for complete details regarding the use of late codes.

Please contact the Provider Relations Unit at (213) 738-3311 if you need additional information.

LOCAL MENTAL HEALTH PLAN
OFFICE OF THE MEDICAL DIRECTOR
MEDI-CAL PROFESSIONAL SERVICES & AUTHORIZATION DIVISION
550 S. Vermont Ave, 7th Floor, Los Angeles, CA 90020
Phone: (213) 738-3311
Fax: (213) 351-2024
Website: http://dmh.lacounty.info

CHANGE IN REIMBURSEMENT TIMELINE

In the Provider Bulletin, Third Edition, Issue 6, network providers were informed that effective July 1, 2009, the reimbursement timeline was four to six weeks from claim submission. However, another change in the payment timeline has become necessary to reduce expenditures to the Department and the new timeline for reimbursement is once per month. The payment schedule, which is effective immediately, is attached for your review.

Network providers will be paid based on claims submitted. The Department will recover an overpayment from providers when a service is not payable from Medi-Cal based on State adjudication.

If you have any questions or need additional information, please contact the Provider Relations Unit at (213) 738-3311.

ADVANCE HEALTH CARE DIRECTIVES

An Advance Health Care Directive is a legal document that states an individual's wishes should they become unable to make physical or mental health care decisions. It allows a person to select a family member or friend to make health care decisions for them, should they be unable to participate in their own health care treatment in the future.

Pursuant to the Code of Federal Regulations, Title 42 and the California Probate Code, it is the policy of the County of Los Angeles – Department of Mental Health (DMH) that all Medi-Cal beneficiaries, 18 years of age and older, be given written information regarding Advance Health Care directives at the time of their first service contact.

In the event a Medi-Cal beneficiary presents a completed Advance Health Care Directive to a DMH directly operated or contract provider, the Advance Health Care Directive is to be placed in the beneficiary's mental health record.

The DMH Advance Health Care Directives Policy and Procedure and the DMH Advance Health Care Directives Fact Sheet are included as an attachment with this Provider Bulletin. You may provide the DMH Fact Sheet to your clients or you may use your own informational materials.

REMINDER - PROVIDER MANUAL, 4TH EDITION, JULY 2009

Network providers were notified in the May 2009, Provider Bulletin, Third Edition, Issue 5, that the Local Mental Health Plan (LMHP) Network Provider Manual would be available on the DMH's Internet website in early July, 2009 to coincide with the contract renewals which were effective July 1, 2009. This is a reminder that the network provider manual has been available for your immediate access and downloads since mid-July 2009. The Network Provider Manual, Fourth Edition, July 2009 may be accessed at the following website: http://dmh.lacounty.gov. Highlight "Administrative Tools for Providers," select "Agency Administration," scroll down to the middle of the webpage and under Provider Manuals, select "Network Provider Manual, Fourth Edition, July 2009."

The Provider Manual and all subsequent Provider Bulletins have the same authority as the contract, which stipulates that providers shall perform specialty mental health services in accordance with the terms and conditions of the contract and the requirements in the LMHP

Provider Manual and Provider Bulletins.

If you are not able to download the manual please contact the Provider Relations Unit at (213) 738-3311 for assistance.

INTERNET REPORTS – AVAILABLE FOR WARRANT RECONCILIATION!

Network providers and billing agents were notified on August 20, 2009, via IS Alert, that Internet Reports were available for access on August 24, 2009. The "Claims Reconciliation Report CIOB 706A," is designed to assist in reconciling warrants received for claims submitted in July 2009 and forward. The "Processed Claims Summary Report CIOB 705A," will serve as a summary report that will list sequence numbers and warrant amounts.

The "Internet Reports" link appears on the lower, left-side of the screen on the "Outpatient Fee-For-Service," website: http://dmh.lacounty.gov/hipaa/ffs_home.htm. The Internet reports require providers and/or billing agents to use two separate logon procedures:

1) Click the "Internet Reports" link, and the user will be prompted to enter the RSA SecurID logon information to access the reports application; and,

2) Another prompt will appear requesting the user to enter the Integrated System (IS) logon ID information to access the reports.

3) Network providers and/or billing agents were supplied with their RSA SecurID logon and IS logon information at the time applications were submitted for IS access and must be used to access the Internet reports.

Individuals who have a damaged, lost or stolen RSA SecurID card should proceed as follows:

1) Network Provider or billing agent (person authorized to sign) must send a letter on company letterhead to the Systems Access Unit stating that the RSA SecurID card was damaged, lost or stolen. The letter must include the user name, logon ID, and provider's or biller's mailing address to send the replacement card. If the old RSA SecurID card serial number and expiration date was retained, please include it in the letter.

2) Complete the SecurID Token Renewal Form and the Agreement for Acceptable Use Form, which may be accessed at the following website address: http://dmh.lacounty.gov/hipaa/downloads/SecurID_Renewal_Non_County.pdf

3) Mail the letter, the SecurID Token Renewal Form and the Agreement for Acceptable Use Form to the CIOB Systems Access Unit, 695 S. Vermont Av., 8th Floor, Los Angeles, CA 90005.

Individuals who possess an RSA SecurID card and logon but do not know their IS logon ID and password should call the Department of Mental Health Helpdesk at (213) 351-1335. Please be prepared to answer the security questions.

Network providers and billing agents who have never applied for IS access and wish to access the Internet Reports must complete the forms identified on the "DDE/EDI Application Processing Checklist." Please contact the Provider Relations Unit at (213) 738-3311 and the checklist will be faxed. The forms from the checklist may be accessed at the following website address: http://dmh.lacounty.gov/hipaa/ffs_ISForms.htm

If you have any questions or need additional information, please contact the Provider Relations Unit at (213) 738-3311.

NOTIFICATION OF UPCOMING CHANGES IN MEDI-CAL CLAIMING REQUIREMENTS

In an effort to become compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the State Department of Mental Health is implementing significant changes to the Short-Doyle/Medi-Cal (SD/MC) claiming system. These changes are known as SD/MC Phase II and will impact all network providers.

Los Angeles County Department of Mental Health (DMH) is working with the State to finalize the business rules and claiming requirements so that the required changes to the Integrated System (IS) can be made prior to the February 1, 2010 final implementation date. In order to assure that all Medi-Cal claims submitted to the State on February 1, 2010 and thereafter meet the new requirements, there will be a transition period during which network providers will not be able to submit services as claims in the IS. Because of the Certified Public Expenditure process and the necessary programming changes and testing that must occur prior to the State's required implementation date, network providers must be current and have all of their Medi-Cal claims submitted into the IS before ***December 1, 2009*** as **all** claims submitted to the Department on and after that date will need to be in the new State format. We expect network providers to be able to resume electronic claiming in February or March 2010. During the week of November 16, 2009, the Department will conduct three training sessions designed to inform network providers of the specific new requirements for claiming and instructions for submitting manual claims during the interim. Please plan to attend at least one of the sessions to be announced at a later date.

All network providers and billing agents need to be aware of this information and prepare for the impact to their internal business operations. Effective December 1, 2009, claiming functions in the IS will be disabled for "ALL" providers until February or March 2010. This means that Electronic Data Interchange (EDI) users will not be able to submit any files and direct data entry (DDE) users will not be able to submit original claims to the IS. As a work around and in an effort to avoid disruption in reimbursement, the Department will allow network providers to submit manual claims as described below.

INSTRUCTIONS TO AVOID DISRUPTION IN REIMBURSMENT:

The Department will e-mail claim forms to network providers to use to enter claims data for service dates beginning December 1, 2009 through March, 2010. The claim forms will contain additional data elements that must be identified by network providers to be captured in the IS to comply with the new State requirements. Network providers shall continue to collect and include the additional data elements in their DDE and EDI claim submissions after the IS has become available. Mail the completed claim forms to a post office box that will be provided at a later date.

The Department is requesting Board of Supervisors approval to amend all legal entity and network provider Agreements for fiscal year 2009-10 to accommodate the transition to the State's new Medi-Cal claiming system. Upon Board approval, every network provider must sign the contract amendment.

ADDITIONAL MODIFICATIONS TO BE IMPLEMENTED AFTER MARCH 2010:

The SD/MC Phase II claiming modifications are the first in a series of necessary changes that will ensure compliance to Federal and State regulations regarding HIPAA and claim submissions. The Department will consolidate the administrative and clinical modules of the IS into one. Network providers will be required to create episodes in the IS prior to submitting claims. There is also a plan to implement a procedure that will allow network providers and billing agents to void and replace claims, a feature that is not currently available. We will continue to keep you informed as these plans are developed and implemented.

An enclosed memo from Robin Kay, Ph.D., Chief Deputy Director of Mental Health contains the attestation network providers are instructed to sign. Please sign, retain a copy and mail this attestation page to the following address by November 20, 2009: Department of Mental Health, Provider Relations Unit, Attention: Kathy Jones, 550 S. Vermont Av., 7th Floor, Los Angeles, CA 90020.

IMPORTANT TELEPHONE NUMBERS

DMH Help Desk	(213) 351-1335
ACCESS (24 hours)	(800) 854-7771
Provider Relations Unit (FFS Providers' First Point of Contact)	(213) 738-3311
Provider Reimbursement	(213) 738-2309
Integrated System Users After Hours Support	(562) 940-0617

DWK:KSJ

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
BUSINESS RULES FOR LATE SUBMISSION OF SHORT-DOYLE/MEDI-CAL MEDI-CAL (SD/MC) CLAIMS FOR GOOD CAUSE REASONS (i.e. LATE CODE USAGE)
September 4, 2009

1. This notification re-emphasizes prior County Department of Mental Health (DMH) communication to service providers about their responsibilities regarding the proper use of good cause late codes. Providers are reminded that any Medi-Cal claim submitted with the use of a late code is subject to audit. No or inadequate documentation for the use of a late code will result in the service(s) being disallowed and reimbursement will be recovered by the State.
    a. Recent State Department of Mental Health (SDMH) review of service providers' use of good cause late codes underscored adherence to late code requirements.
    b. Claims with a good cause late code submitted by a service provider to DMH are subject to the business rules in this document.
    c. It is the provider's responsibility to select the applicable late code only when there is a good cause for the late submission. Therefore, it is necessary for the provider to review each individual claim to determine if there is good cause to submit the claim with the expectation that Federal reimbursement will be approved.
    d. The late codes and good cause reasons are the same as previously provided to service providers by the DMH.
    e. These business rules elaborate on DMH's operational procedures for the referenced late codes. The detail in these business rules is to reinforce the importance of correct late code use.
    f. These business rules remain in effect until the implementation of SD/MC II at which time the late code process is to be fully electronically conducted.
    g. Notwithstanding the claims submission dates in these business rules contracted service providers must comply with the submission dates set forth in their *Legal Entity Agreement Financial Exhibit A (Financial Provisions)* for claims submission, specifically,
        i. Paragraph F. *Billing Procedures*, Subparagraph (3) *Mental Health Services* " Claims for all mental health services, including services funded by Title XIX Short-Doyle/Medi-Cal and Title XXI Healthy Families, shall be entered into the County's claims processing information system within 30 calendar days of the end of the month of the service in which services are delivered. ..."
        ii. Paragraph F. Subparagraph (3) (b) "The County may, in the exercise of its sole reasonable discretion, extend the time to submit an initial or original claim to within four (4) months after the end of the month in which the services were rendered, ..."
        iii. Paragraph F. Subparagraph (3) (c) "The County may, using reasonable discretion, extend the time to submit claims for services under Title XIX Short-Doyle/Medi-Cal or under Title XXI Healthy Families to within ten (10) months after the end of the month in

which the services were rendered where good cause for the delayed submission would be recognized under California Code of Regulations (CCR), Title 22 Section 51008.5."

2. Authority for the use of Medi-Cal Late Codes is governed by Federal and California statutes.
    a. All service providers shall comply with the federal and State regulations regarding the use of good cause late codes. See Attachment I for California Code of Regulations citations.
    b. These business rules are intended to supplement the information in Attachments I and II.

3. Claims entered into the DMH claims processing information system (Integrated System also known as IS) that are less than six months from the day of service do not require the use of a good cause late code and should be entered into the IS as required in the Legal Entity Agreement's Paragraph F. Subparagraph (3) (b) (see above 1. g. ii.).
    a. The timing of claims submission is important with the IS editing claims at "...less than six months from the *day* (emphasis added) of service" and the CCR indicating "...not later than the sixth month following the *month* (emphasis added) of service ...".
        i. The 22 CCR § 51008 (a) indicates " Except for good cause, bills for services provided pursuant to the Medi-Cal Program ..., shall be received by the fiscal intermediary, or otherwise as designated by Director, not later than the sixth month following the month of service ...".
        ii. The significance is DMH contractually establishes the day of service as the control point in contrast to the CCR which uses the month of service.
    b. While a claim may be billed with the use of a late code for a service that is no more than six months from the date of service that is an oddity and will not have an impact on the State's adjudication of the claim.

4. Applicable good cause reason(s) as specified in 22 CCR, Division 3, Subdivision 1, Chapter 3, Article 1.3, Sections 51008 and 51008.5 must be provided by the service provider for each claim that is billed seven to 12 months from the month of service.
    a. Late claim means a claim is submitted to the State more than six months after the date of service.

b. Service provider must provide a good cause late code for each late claim that is being billed to DMH. See Attachment II for good cause delay reason code crosswalk and descriptions.
c. The IS applies the time limitation to 12 months from the *date of service* (i.e. the date of service is used and not the month of service).
d. Special circumstances claims are billable beyond 12 months from the month of service. Again, the IS applies the time limitation to 12 months from the *date of service* (i.e. the date of service is used and not the month of service). Such special circumstances claims must be manually submitted by the service provider for processing.
e. On August 3, 2009 an Integrated System Data Modification Request was initiated which will deny for EDI providers and will not allow to submit for DDE providers all Medi-Cal billable claims where the date of service is > than six (6) months from the day of service and does not contain a valid late code. This new edit only addresses claims that at the time of IS processing are known to be late.
    i. The IS edit is:

Edit	DDE Error Message	EDI Rule
Do not allow claims to be submitted that are over 6 months late, are Medi-Cal billable and do not have a late code	• 'Late Code is required as Service Date is over 6 months and service is Medi-Cal billable.'	• 837p Rule 86 – New Rule • 837i Rule 56 – New Rule

f. On August 3, 2009 an Integrated System Data Modification Request was initiated which will deny for EDI providers and will not allow to submit for DDE providers all Medi-Cal billable claims where the claim is over 12 months from the day of service.
    i. The IS edit is:

Edit	DDE Error Message	EDI Rule
Do not allow claims to be submitted that are more than 12 months late and are Medi-Cal billable	'Cannot claim for services more than 12 months late and service is Medi-Cal billable. Please submit claim manually'.	837p Rule 28 – Modification to existing rule 837i Rule 21 – Modification to existing rule

5. Service provider shall retain and make available substantiating documentation for the late code good cause at the service provider's premises. Such documentation shall be presented on request by the service provider to the California Department of Mental Health, California Department of Health Care

Services, County Department of Mental Health, Centers for Medicare and Medicaid, and/or other State or federal Medi-Cal program personnel. Generally such requests for documentation are to be responded to within 30 or less calendar days from the date of notification.

6. Federal and State Medi-Cal requirements require the service provider to report all units of service associated with reported expenditures. This requirement is to avoid cost shifting to federal programs such as Medi-Cal. Accordingly claims denied by IS are reportable irrespective if they are compensated or uncompensated.

7. Claims associated with each of the respective late codes identified in Paragraph 8 require the preparation and completion of the following forms:
   a. Service provider *Good Cause Certification* letter - (certification described below). This form is to be prepared by the rendering service provider.
      i. The service provider is to certify either each specific claim/claims file or on an annual basis that the use of late code(s) was true, proper and in compliance with the requirements of the respective late codes. See Attachment III-A and III-B for the service provider certification forms for each specific claim/claim file or annual basis respectively.
   b. State of California *Good Cause Certification Letter,* MH 1770 form.
      i. DMH shall complete a *Good Cause Certification Letter,* MH 1770 by checking the appropriate box(es), dating, and signing. See Attachment IV for MH 1770.
      ii. This form is to be prepared by the DMH Data Management Division, Financial Services Bureau.
   c. Letter from DMH Director or Chief Deputy Director to State explaining the reason for the use of the late code. This letter is to be prepared by the service provider and forwarded to the DMH Data Management Division, Financial Services Bureau for processing to the DMH Director/Chief Deputy Director.

These documents are then to be forwarded to the State along with the services claims files by the DMH Data Management Division, Financial Services Bureau in the following steps:

- Scan to PDF file and mail to marcelo.acob@dmh.ca.gov
- Mail the original copy by certified mail to the attention of:

  Marcelo Acob
  MCCC – California Department of Mental Health
  1600 9th Street, Room 400
  Sacramento, CA 95814

8. Good Cause Codes for Late Submission of Medi-Cal Claims, Authorizing Party, and documentation in addition to the certification form(s) and letter required in the above Paragraph 7:
    a. The IS to have the capability for service providers to enter the following late codes for claims on either a non-restricted or restricted basis.
        i. Non-restricted means the service provider can enter a claim into the IS using a particular late code (identified below) without any prior Department approval.
        ii. Restricted means that before a service provider has the ability to enter a claim into the IS said service provider must obtain prior DMH authorization to use the particular late code.
    b. Procedure for non-restricted late code. The service provider upon determination that a late code identified as unrestricted by DMH can proceed to enter the unrestricted late code into the IS when appropriate for a claim.
    c. Procedures for restricted late code. The IS has the capability for the service provider to use the late codes noted as restricted. However, the service provider is locked out of the ability to actually bill any service(s) with the use of any one of these restricted late codes until the delegated DMH authority authorizes DMH Chief Information Office Bureau (CIOB) to allow the service provider to use the restricted late code. Once CIOB receives the authorization to allow the service provider to use the restricted late code CIOB would release the lock out.
    d. DMH restricted and unrestricted late codes.
        i. The IS needs the capability to turn on/off the restricted/unrestricted functional feature of the service provider's ability to be able to enter service claims with the use of the late code.
        ii. The restrict flag on/off may be time limited or unlimited. The DMH authorizing party would designate the applicable time period, if any, that the service provider is authorized to use the late code. The IS functionality would need to include the allowable time period which may need to be periodically renewed if say a natural disaster was the cause and no end date was originally known. However, all claims are subject to the requirement that any claim billed after the 12th month from the month of service is to be denied.
    e. SD/MC late code A (HIPAA delay reason code 1). Non-restricted late code. Service provider would indicate this late code when billing.
        i. Substantiating documentation to justify the late claim that is responsive to the delay reason code description provided in Attachment II, including but not limited to records showing specific

dates when a client was identified and determined to be eligible for Medi-Cal benefits.

f. SD/MC late code B (HIPAA delay reason code 7). Non-restricted late code. Service provider would indicate this late code when billing.
    i. Substantiating documentation that is responsive to the delay reason code description provided in Attachment II.
g. SD/MC late code C (HIPAA delay reason code 8). Non-restricted late code. Service provider would indicate this late code when billing.
    i. Substantiating documentation that is responsive to the delay reason code description provided in Attachment II.
h. SD/MC late code D (HIPAA delay reason code 4 - delay in certifying provider). Restricted late code. Service provider will not be able to enter the late code until DMH approval is received. However, until the IS is modified no legal entity other than DMH has the ability to enter into the IS late code 4 even when authorized by the DMH Program Support Bureau (PSB) for delayed claim submissions resulting from delayed Medi-Cal certification. Accordingly the DMH will enter the late code 4 into the IS after the contractor has coordinated the need with PSB and the PSB has authorized the legitimate use of late code 4.
    i. As of June 25, 2009, late code 4 claim designation by the service provider has not been accepted in the IS unless authorized by the PSB.
    ii. The use of late code 4 for the service provider must be approved by the PSB prior to the service provider having the ability to enter claims using late code 4.
    iii. Th e IS currently does not have the functionality to allow a service provider to enter late code 4. DMH at a future time will develop the IS capability to flag a certain provider with the late code 4 designation for a certain period of time and for a certain date of service date range. The work around procedure for late code 4 processing to be used until the functionality is added to the IS is provide in Attachment V.
    iv. The PSB's authorization does not apply to claims submitted by the service provider more than 12 months beyond the month of service.
    v. PSB's authorization will also designate the applicable months for appropriate use of late code 4.
    vi. Until such time that the IS is modified the DMH Revenue Management Division (RMD) will enter and/or identify claims requiring late code 4. Such RMD action shall not be taken until the service provider has formally in writing notified RMD of the applicable claims.

i. SD/MC late code D (HIPAA delay reason code 11 (Other). Restricted late code. Service provider will not be able to enter the late code until DMH approval is received. The use of this late code for the provider must be approved by the DMH Managed Care Division before forwarding to the State for adjudication.
    i. Generally late code 11 is used by DMH for TAR delays.
    ii. These claims are to be segregated by Sierra Systems into a separate file.

j. SD/MC late code E (HIPAA delay reason code 10). Not in use by DMH. Future State DMH instructions will be necessary for authorized use of late code 10.
    i. To be considered a restricted late code until any State instructions that are received have been evaluated by the DMH. Service provider will not be able to enter the late code until DMH approval is received.

k. SD/MC late code F (HIPAA delay reason code 2). Currently an unrestricted late code. However, the use of this late code by the provider must be approved by the PSB in collaboration with the DMH Emergency Outreach Bureau Disaster Services/Programs.
    i. Currently all providers have the IS functionality to enter late code F (HIPAA late code 2). The proper use of this late code will be monitored by the DMH.

9. Claims submitted beyond one year (12 months) from the date of service are to be denied by the IS.
    a. Special circumstances that cause a billing delay beyond the time limitations specified in 22 CCR Section 51008/51008.5 (i.e. for DMH more than 12 months from the date of service) may be manually submitted to RMD with documentation supporting that either court decision or a State hearing decision was the reason for the delay. The DMH will coordinate with the State what action is to be taken prior to County payment of the claim and claim submission to the State.
        i. An IS edit is in place which will deny for EDI providers and not allow to submit for DDE providers all Medi-Cal billable claims where the date of service is > than 12 months from the month of service. See above Paragraph 4. f.

10. Dispute Resolution Process – This process shall be used in the event a claim is submitted by the service provider with a late code and the late code was determined by the DMH to be an invalid late code and the service provider disputes the DMH finding.

a. Disputes regarding the use of late codes are to be submitted in writing with supporting documentation to the RMD within 10 working days from the DMH notice of claim denial. Definition: Notice of claim denial means the date the CIOB releases to the service provider an IS report that shows the denial.
b. RMD will provide its findings to the service provider within 10 business days of the receipt of the written dispute material.
c. State and federal statutory and regulatory good cause late code requirements shall prevail because County has no jurisdiction regarding late code requirements.

END OF DOCUMENT

COUNTY OF LOS ANGELES

MARVIN J. SOUTHARD, D.S.W.
Director

ROBIN KAY, Ph.D.
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

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DEPARTMENT OF MENTAL HEALTH

http://dmh.lacounty.gov

Reply To: (213) 738-3311
Fax. (213) 351-2024

November 5, 2009

TO: Individual, Group and Organizational Network Providers

FROM: Robin Kay, Ph.D.
Chief Deputy Director
Department of Mental Health

SUBJECT: **NOTIFICATION OF UPCOMING CHANGES IN MEDI-CAL CLAIMING REQUIREMENTS**

In an effort to become compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the State Department of Mental Health is implementing significant changes to the Short-Doyle/Medi-Cal (SD/MC) claiming system. These changes are known as SD/MC Phase II and will impact all network providers.

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Please sign, retain a copy and mail this attestation page to the following address by November 20, 2009: Department of Mental Health, Provider Relations Unit, Attention: Kathy Jones, 550 S. Vermont Av., 7th Floor, Los Angeles, CA 90020.

My signature below attests that I am aware of the pending changes that will affect claims submission through the Integrated System (IS), either by Electronic Data Interchange (EDI) or through Direct Data Entry (DDE). In addition, I understand that through a manual processing system I will need to collect and add additional information to be submitted as a claim after the IS has become available.

Nine-Digit Provider # _____ Individual, Group or Organizational Network Provider Name _____

Executive Director/Group Administrator/Network Provider Name (Please print) _____

Executive Director/Group Administrator/Network Provider Signature _____ Date _____

Multiple Nine-Digit Provider Numbers _____ Telephone Number _____

Questions may be directed to Kathy Jones at (213) 738-2627 or to the Provider Relations Unit at (213) 738-3311.

RK:PW:kj

c: Roderick Shaner, M.D.
Pansy Washington
Kathy Jones
Donna Warren-Kruer

DEPARTMENT OF MENTAL HEALTH
POLICY/PROCEDURE

SUBJECT	POLICY NO.	EFFECTIVE DATE	PAGE
ADVANCE HEALTH CARE DIRECTIVES	**200.3**	**06/01/04**	**1 of 2**
APPROVED BY: Director	SUPERSEDES	ORIGINAL ISSUE DATE	DISTRIBUTION LEVEL(S) **2**

PURPOSE

1.1 The purpose of this policy and procedure is to be consistent with the requirements of Title 42, Code of Federal Regulations, Section 422.128 to ensure adult Medi-Cal beneficiaries served by the Los Angeles County Mental Health Plan (MHP) are provided with information (see Attachment I) concerning their rights under California State Law regarding Advance Health Care Directives and to ensure the information is updated when there are changes in State Law.

POLICY

2.1 It is the policy of the Los Angeles County Department of Mental Health (LACDMH) that all Medi-Cal beneficiaries over the age of 18 be given information concerning their rights under California State Law regarding Advance Health Care Directives at their first face-to-face contact for services and thereafter upon request by a Medi-Cal beneficiary.

2.2 In the event a beneficiary presents a specific completed, properly executed Advance Health Care Directive, the document shall be placed in the beneficiary's mental health medical record.

2.3 Provision of care is not conditioned on whether or not a beneficiary has executed an advance directive.

PROCEDURE

3.1 Medi-Cal beneficiaries, 18 years of age and older, shall be provided written information regarding Advance Health Care Directives at the time of the first face-to-face service contact and thereafter upon request.

3.2 Informational material regarding Advance Health Care Directives shall be maintained in compliance with existing California State Law and will be updated to reflect changes in State Law within 90 days of the implementation of a change.

3.3 In the event a Medi-Cal beneficiary presents a completed, properly executed Advance Health Care Directive to staff members of a directly operated or contracted provider, the Advance Health Care Directive shall be placed in the beneficiary's mental health record.

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3.4 Agencies shall document in a prominent part of the beneficiary's current health care record whether or not an Advance Health Care Directive has been executed.

REFERENCES

California Probate Code, Sections 4600 et seq, 4677, 4678, 4686, 4689, 4695, 4730, 4731, 4732, 4740, and 4742

ATTACHMENT

Attachment I Information Regarding Advance Health Care Directives

REVIEW DATE

This policy shall be reviewed on or before August, 2009.

ADVANCE HEALTH CARE DIRECTIVES
FACT SHEET

What is an Advance Health Care Directive?
An Advance Directive is a legal document that allows an individual to state in advance their wishes should they become unable to make healthcare decisions.

In California, an Advance Directive consists of two parts: (1) appointment of an agent for healthcare; and (2) individual health care instructions.

What can an Advance Health Care Directive do for a person with a psychiatric disability?

- It allows you to make treatment choices now in the event you need mental health treatment in the future. You can tell your doctor, institution, provider, treatment facility, and judge what types of treatment you do and do not want.
- You can select a friend or family member to make mental health care decisions, if you cannot make them for yourself.
- It can improve communications between you and your physician.
- It may reduce the need for long hospital stays.
- It becomes a part of your medical record.

Who can fill out an Advance Health Care Directive?
Any person 18 years or older who has the "capacity" to make health care decisions. "Capacity" means the person understands the nature and consequences of the proposed healthcare, including the risks and benefits.

When does an Advance Health Care Directive go into effect?
An Advance Health Care Directive goes into effect when the person's primary physician decides the person does not have the "capacity" to make their own healthcare decisions. This means the individual is unable to understand the nature and consequences of the proposed healthcare.

The fact that a person has been admitted into a psychiatric facility does not mean the person lacks "capacity".

How long is an Advance Health Care Directive in effect?
In California, an Advance Health Care Directive is indefinite. You can change your mind at any time, as long as you have the "capacity" to make decisions. It is a good idea to review your Advance Health Care Directive yearly to make sure your wishes are stated.

Do I have to have an Advance Health Care Directive?
No. It is just a way of making your wishes known in writing, while you are capable. Your choices are important.

Where do I get legal advice about an Advance Health Care Directive?
Your Attorney
Protection and Advocacy, Inc.
Mental Health Association of Los Angeles
(213) 250-1500, Ext. 19

Where can I get the Advance Health Care Directive Forms?
Stationary Stores
Mental Health Association of Los Angeles
(213) 250-1500, Ext 19
Your Attorney

Who should have a copy of the Advance Health Care Directive?

- You. Your Advance Health Care Directive should be kept in a safe place, but easily accessible.
- Your agent; the person designated to make health care decisions if you are unable to do so.
- Each of your health care providers;
- Each of your mental health providers.

It is important that you keep track of who has a copy of your Advance Health Care Directive in case you make changes in the document.

Complaints concerning non-compliance with the advance directive requirements may be filed with the California Department of Health Services (DHS) Licensing and Certification by calling 1-800-236-9747 or by mail at P.O. Box 997413, Sacramento, California 95899-1414.

COUNTY OF LOS ANGELES

MARVIN J. SOUTHARD, D.S.W.
Director

ROBIN KAY, Ph.D.
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

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DEPARTMENT OF MENTAL HEALTH

http://dmh.lacounty.gov

Reply To: (213) 738-4684
Fax: (213) 381-7092

October 6, 2009

Dear Fee For Service Network Provider:

RE: Extension for Receipt of Sexual Misconduct Liability Insurance

The Department of Mental Health (DMH) would like to reassure you that your contract **will not** be terminated October 31, 2009 for non compliance with the new and/or revised minimum liability insurance requirements.

The Department of Mental Health (DMH) is currently involved in discussions with our County Counsel, Chief Executive Office (CEO) and the CEO's Risk Management Branch/Operations staff to resolve issues pertaining to the new insurance requirements. As these issues are resolved, we will keep you informed.

It would be helpful for us to know what specific attempts you have made and any obstacles you are encountering. This will assist us in our discussions with the Risk Management Operations staff. Please email your comments to Stephen Zhou at szhou@dmh.lacounty.gov.

Sincerely,

Richard Kushi, Chief
Contracts Development
and Administration Division

RK:LQ

cc: Robin Kay, Ph. D.
Roderick Shaner, M.D.
Margo Morales
Pansy Washington

COUNTY OF LOS ANGELES

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DEPARTMENT OF MENTAL HEALTH

http://dmh.lacounty.gov

Reply To: (213) 738-3311
Fax: (213) 351-2024

September 11, 2009

TO: Service Providers

FROM: Kathy S. Jones
Acting Program Manager

SUBJECT: **PROVIDER SATISFACTION SURVEY**

The Los Angeles County Department of Mental Health (DMH) is devoted to continuous quality improvement. As part of this effort, we are conducting a survey of service providers doing business with the various authorization sections within Medi-Cal Professional Services and Authorization Division (Out-of-County, Over-threshold, Psychological Testing and Day Treatment/TBS) during this calendar year.

In order to assess the quality of our work, and to indentify how we can improve our services, we are asking for your cooperation in answering the questions below. Please complete the enclosed *Provider Satisfaction Survey* by selecting and entering a number rating in the boxes next to the questions and **fax your responses to (213) 351-2024 no later than October 6, 2009.** Also, please remember to select your discipline in the top header of the survey. You may also mail your survey to the following address:

Los Angeles County/Dept. of Mental Health
Medi-Cal Professional Services, Attn: Kathy Jones
550 South Vermont Avenue, 7th Floor, Room 704A
Los Angeles, CA 90020

Thank you for your valuable time. I look forward to your response.

If you have any questions or need additional information, please do not hesitate to contact me at (213) 738-3311.

KSJ:ksj

Attachment

c: Pansy Washington
Donna Warren-Kruer

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
OFFICE OF THE MEDICAL DIRECTOR – MANAGED CARE DIVISION
MEDI-CAL PROFESSIONAL SERVICES AND AUTHORIZATION DIVISION

☐MD ☐PHD/PsyD ☐MFT☐ LCSW ☐NP/CNS

PROVIDER SATISFACTION SURVEY

OUT-OF-COUNTY

1 = Strongly Agree **2 = Agree** **3 = Somewhat Agree** **4 = Strongly Disagree** **5 = Disagree** **6 = Somewhat Disagree**	#
1. Within the last year, have you had contact with the Out-of-County Section? **(Yes or No)**	
2. The staff was courteous and responsive to my needs.	
3. Has a request for authorization ever been changed, modified, or denied? (Yes or No)	
a. If so, did you receive a copy of the NOA?	
b. Do you know if the client filed for a fair hearing?	
c. Did you appeal this decision?	
d. Were you able to provide additional documentation to support medical necessity?	
4. Overall, I am satisfied with the service and timeliness of responses.	
5. Suggestions for Improvement:	

OVERTHRESHOLD

1 = Strongly Agree **2 = Agree** **3 = Somewhat Agree** **4 = Strongly Disagree** **5 = Disagree** **6 = Somewhat Disagree**	#
1. Within the last year, have you had contact with the Over-threshold Section? **(Yes or No)**	
2. The staff was courteous and responsive to my needs.	
3. Has a request for authorization ever been changed, modified, or denied? (Yes or No)	
a. If so, did you receive a copy of the NOA?	
b. Do you know if the client filed for a fair hearing?	
c. Did you appeal this decision?	
d. Were you able to provide additional documentation to support medical necessity?	
4. Overall, I am satisfied with the service and timeliness of responses.	
5. Suggestions for improvement:	

PSYCHOLOGICAL TESTING AUTHORIZATION

1 = Strongly Agree **2 = Agree** **3 = Somewhat Agree** **4 = Strongly Disagree** **5 = Disagree** **6 = Somewhat Disagree**	#
1. Within the last year, have you had contact with the Psychological Testing Section? **(Yes or No)**	
2. The staff was courteous and responsive to my needs.	
3. Has a request for authorization ever been changed, modified, or denied? (Yes or No)	
a. If so, did you receive a copy of the NOA?	
e. Do you know if the client filed for a fair hearing?	
f. Did you appeal this decision?	
g. Were you able to provide additional documentation to support medical necessity?	
4. Overall, I am satisfied with the service and timeliness of responses.	
5. Suggestions for improvement:	

☐MD ☐PHD/PsyD ☐MFT☐ LCSW ☐NP/CNS

DAY TREATMENT

1 = Strongly Agree 4 = Strongly Disagree	2 = Agree 5 = Disagree	3 = Somewhat Agree 6 = Somewhat Disagree	#
1. Within the last year, have you had contact with the Day Treatment/TBS Section? (**Yes or No**)			
2. The staff was courteous and responsive to my needs.			
3. Has a request for authorization ever been changed, modified, or denied? (Yes or No)			
a. If so, did you receive a copy of the NOA?			
h. Do you know if the client filed for a fair hearing?			
i. Did you appeal this decision?			
j. Were you able to provide additional documentation to support medical necessity?			
4. Overall, I am satisfied with the service and timeliness of responses.			
5. Suggestions for improvement:			

KSJ:
09/2009